STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155738	B. WING		08/09/2011
NAME OF	PROVIDER OR SUPPLIE	IR.		ADDRESS, CITY, STATE, ZIP CODE	
MILTON	HOME		I	MARION ST HBEND, IN46601	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
K0000					
	A Life Sefety	Codo Poportification	K0000	•	
	1	Code Recertification	Kooo		
	1	ensure Survey was			
	1	the Indiana State			
	1 *	of Health in accordance			
	with 42 CFR	483.70(a).			
	Survey Date:	08/09/11			
	Facility Num	ber: 001141			
	Provider Nun	nber: 155738			
	AIM Number	:: 200905640			
	Surveyor: Ri	chard D. Schade, Life			
	Safety Code S	Specialist			
	At this Life S	afety Code survey,			
	1	was found in			
	substantial co	empliance with			
		s for Participation in			
	1 ^	dicaid, 42 CFR			
	1	70(a), Life Safety from			
	_	2000 edition of the			
	National Fire				
	1	NFPA) 101, Life			
	1	(LSC), and 410 IAC			
		nt rooms 118 thru 127			
	located on the	e first floor of the			
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YMT921

Facility ID:

001141

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155738	A. BUII		01	08/09/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				MARION ST		
MILTON	HOME			SOUTH	I BEND, IN46601		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAU	1975 building			IAG	,		DATE
		Chapter 19, Existing					
Health Care Occupancies							
		coupanoies					
	The nursing ac	ldition of the facility					
	_	orinklered, two story					
		n unsprinklered					
	· ·	was determined to be					
	of Type II (111) construction. The					
	original buildi	ng was constructed in					
	1952 with the	nursing addition					
	added in 1975	located on the first					
	and second flo	ors. The facility has					
	a fire alarm sy	stem with smoke					
		e corridors, resident					
	sleeping rooms	s and spaces open to					
	the corridors.	The facility has a					
	capacity of 34	and had a census of					
	25 at the time	of this survey.					
		Robert Booher, Life Safety dical Surveyor on 08/18/11.					
	Code Specianst-Met	aicai baiveyoi on 00/10/11.					
	The facility wa	as found in					
	_	npliance with the					
	aforementione	-					
		as evidenced by the					
	following:	•					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE (COMPL 08/09/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER		p. w.i.v.	STREET A	DDRESS, CITY, STATE, ZIP CODE IARION ST BEND, IN46601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K0064 SS=B	Portable fire exting health care occupa 9.7.4.1. 19.3.5.6 Based on obse interview, the ensure 1 of 1 pextinguishers i readily identifit backup to the a suppression sy 1998 Edition, extinguishers to conspicuously states the autor system is to be using the fire edeficient pract and near the killing based on obse	guishers are provided in all ancies in accordance with 5, NFPA 10 rvation and facility failed to portable fire in the kitchen was a secondary automatic fire stem. NFPA 10, 2-3.2.1 requires fire in clude a placed placard which matic fire protection activated before extinguisher. This ice affects all staff in tchen. de:	K0	0064	A bilingual placard is in place stating, "Caution, In case of appliance fire, actuate fixed suppression system before u extinguisher". An environmen audit has determined that this deficient practice does not exany where else in the facility assure that this deficient practice does not recur, The Director Maintenance will verify that the sign is still posted each month when inspecting the fire extinguishers. Additionally, a staff will be inserviced on the need to activate the automatisupression system prior to us the portable extinguisher in the kitchen. The results of the monthly inspections will be reported to the Quality Assur Committee quarterly.	sing tal s kist To ctice of ne h all sc fire sing ne	09/08/2011
	maintenance st 08/09/11 at 3:4	upervisor on 15 p.m., a placard was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 08/09/2	ETED
NAME OF F	PROVIDER OR SUPPLIER		•	206 E M	DDRESS, CITY, STATE, ZIP CODE IARION ST BEND, IN46601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0154 SS=C	maintenance s acknowledged placed near the 3.1-19(b) Where a required is out of service for 24-hour period, the jurisdiction is notifically evacuated or an axis provided for all put the shutdown until been returned to so Based on recommendation in the provide a writing procedures to protect 34 of 3 event the autor system has to service for 4 h hour period in LSC, Section 9 requires sprink	automatic sprinkler system r more than 4 hours in a e authority having led, and the building is pproved fire watch system barties left unprotected by the sprinkler system has service. 9.7.6.1 and review and facility failed to ten policy containing	K	0154	The facility's policy regarding loss of the fire detection system has been revised to include the automatic sprinkler system. Be revising this policy, all other residents who could have be affected by this deficient practical staff will be inserviced on policy revision regarding the of the automatic sprinkler system and implementing a fire water This information will be provided all new hires and annually other staff. The Quality Assuration Committee will review each occurrence, as it happens, of loss of the alarm system and	em the ty en ctice ally, the loss stem th. ded to all ance	09/08/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738			(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPI 08/09/2	LETED
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE MARION ST BEND, IN46601	-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	Standard for In and Maintenar Fire Protection 11-5(d) require department to sprinkler imparequires the incompany, built and other auth jurisdiction als This deficient all occupants including residusitors. Findings inclusion and promaintenance so 08/09/11 at 2:2 watch proceduservice automa was missing. policy and proservice fire ala not include the The maintenar	nspection, Testing nce of Water Based n Systems. NFPA 25, es the local fire be notified of a irment and 11-5(e) surance carrier, alarm ding owner/manager orities having so to be notified. practice could affect n the facility dents, staff and de: ew of the facility's cedure book with the			sprinkler system to assure policy is followed.	the	

001141

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 08/09/2011		
NAME OF I	PROVIDER OR SUPPLIER		206 E N	ADDRESS, CITY, STATE, ZIP CODE MARION ST I BEND, IN46601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	ΓΙΟΝ
K0155 SS=C	available to reasonable to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel appears of the same available to all personnel a plantage of the same available to all personnel appears of the same available to all pe	fire alarm system is out of than 4 hours in a 24-hour sity having jurisdiction is uilding is evacuated or anoth is provided for all parties of the shutdown until the fire been returned to service. Indicate the shutdown until the fire been returned to se	K0155	The facility's policy regard loss of the fire detection/sysystem has been revised include notifying the author having jurisdiction (local fire department) and their tele number. By revising the poother residents who could affected by this deficient phave been corrected. Additionally, all staff will be inserviced on the policy reregarding notifying the authoring jurisdiction (local fire department). This informate be provided to all new hire annually to all other staff. Quality Assurance Commit review each occurrence, a happens, to assure the authoring jurisdiction is notified the event of the loss of the	orinkler ori	2011

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738			ULTIPLE CO LDING	NSTRUCTION 01	COMPLET	ED
		155738	B. WIN			08/09/201	1
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MILTON	HOME			1	BEND, IN46601		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE C	OMPLETION DATE
		e instructed and kept		_	detection/sprinkler system.		
	1	respect to their					
	duties under th	•					
		19.7.1.2 through					
	19.7.2.3 shall	apply. 19.7.2.2					
	requires all fir	e safety plans to					
	provide for the	e use of alarms, the					
	transmission o	of the alarm to the fire					
	department an	d response to alarms.					
	19.7.2.3 requii	res health care					
	personnel to b	e instructed in the use					
	of a code phra	se to assure					
	transmission o	of the alarm during a					
	malfunction of	f the building fire					
	alarm system.	This deficient					
	practice could	affect all residents,					
	staff and visito	ors.					
	Findings inclu	de:					
	Based on revie	ew of the facility's					
		cedure book with the					
	maintenance s	upervisor on					
	08/09/11 at 2:3	35 p.m., the fire					
	watch procedu	re for an out of					
		atic alarm system was					
	_	The procedure					
	_	uired telephone					
	number for the	e local fire					
			-			-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 01	(X3) DATE S COMPLI		
THISTERN	or conduction	155738	A. BUII B. WIN			08/09/20	
NAME OF D	DOVIDED OD STIDDI IED		b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			1	MARION ST		
MILTON I			_		I BEND, IN46601		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	department. T	The maintenance	ĺ			Ĭ	
	supervisor stat	ed at the time of					
	record review,	he had no other					
	policy or proce	edure available to					
	review.						
	3.1-19(b)						
K0000			İ			İ	
	A Life Sefety	Cada Dagartification	V(0000		ł	
	-	Code Recertification nsure Survey was	K	,000			
		the Indiana State					
	•	Health in accordance					
	-						
	with 42 CFR 4	103.70(a).					
	Survey Date:	08/09/11					
	Sarvey Date.	00,07,11					
	Facility Numb	er: 001141					
	Provider Numl						
	AIM Number:						
	Surveyor: Ric	hard D. Schade, Life					
	Safety Code S ₁	pecialist					
		fety Code survey,					
	Milton Home	was found in					
	substantial con	npliance with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 02	(X3) DATE COMPI 08/09/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE 1ARION ST BEND, IN46601	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	Requirements Medicare/Med Subpart 483.70 Fire and the 20 National Fire I Association (N Safety Code (I 16.2. Residen located on the 1975 building surveyed with Health Care O The nursing ac is a partially sp facility with an basement and of Type II (111) original buildi 1952 with the added in 1975 and second flo a fire alarm sy detection in th sleeping room the corridors.	for Participation in licaid, 42 CFR 0(a), Life Safety from 000 edition of the Protection NFPA) 101, Life LSC), and 410 IAC trooms 218 thru 227 second floor of the addition were Chapter 18, New ccupancies ddition of the facility prinklered two story nunsprinklered was determined to be 1) construction. The ng was constructed in nursing addition, located on the first fors. The facility has stem with smoke e corridors, resident is and spaces open to The facility has a and had a census of					

001141

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738			(X2) MULTIPLI A. BUILDING	E CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/09/2011
		100706	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	06/09/2011
NAME OF F	PROVIDER OR SUPPLIER		I .	E MARION ST	
MILTON	HOME		sou	JTH BEND, IN46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K0154 SS=C	The facility was substantial consaforementioned requirements as following: Where a required is out of service for 24-hour period, the jurisdiction is notified evacuated or an assis provided for all the shutdown until been returned to see Based on reconsistency interview, the provide a writing procedures to protect 34 of 3 event the autors system has to service for 4 hour period in LSC, Section frequires sprink	as found in mpliance with the d regulatory as evidenced by the automatic sprinkler system r more than 4 hours in a e authority having led, and the building is pproved fire watch system parties left unprotected by the sprinkler system has hervice. 9.7.6.1 rd review and facility failed to ten policy containing	K0154	The facility's policy regarding loss of the fire detection syste has been revised to include the automatic sprinkler system. Be revising this policy, all other residents who could have been affected by this deficient practical has been corrected. Aditionally staff will be inserviced on the policy revision regarding the of the automatic sprinkler system and implementing a fire watch that information will be provided all new hires and annually other staff. The Quality Assurations committee will review each occurrence, as it happens, of loss of the alarm system and	the 09/08/2011 em he y en stice ally, the loss stem h. ded to all ance

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	02	COMPL	ETED
		155738	B. WIN			08/09/2	011
NAME OF S	DD OLUBED OD GUDDU IGI				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI			206 E M	MARION ST		
MILTON				L	BEND, IN46601		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	•		-	IAG	sprinkler system to assure th	ıe	DAIL
		nspection, Testing nce of Water Based			policy is followed.		
		n Systems. NFPA 25,					
	1	es the local fire be notified of a					
	1	airment and 11-5(e)					
	1 ^	surance carrier, alarm					
		lding owner/manager					
		norities having					
	jurisdiction al	so to be notified.					
	This deficient	practice could affect					
	all occupants	in the facility					
	including resid	dents, staff and					
	visitors.						
	Findings inclu	ide:					
	Based on revi	ew of the facility's					
	1	ocedure book with the					
	maintenance s						
		35 p.m., the fire					
		are for an out of					
	1 -	atic sprinkler system					
		The facility had a					
	1	.					
	1	ocedure for an out of					
		arm system which did					
		e sprinkler system.					
		nce supervisor stated					
	at the time of	record review, no					
	I .						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY O2 COMPLETED			
		155738	A. BUILDING B. WING		08/09/2011
MILTON			STREET A	ADDRESS, CITY, STATE, ZIP CODE MARION ST I BEND, IN46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0155 SS=C	available to reasonable to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel a plantage of the same available to all personnel appears of the same available to all personnel ap	fire alarm system is out of than 4 hours in a 24-hour ty having jurisdiction is uilding is evacuated or anoth is provided for all parties of the shutdown until the fire been returned to service. Indicate the fire alarm that is a service to be the event the fire alarm the placed out of the placed out of the protect 34 of 34 cordance with LSC and LSC 19.7.1.1 the alth care that is a service to the place to the place that is a service to the placed out of the	K0155	The facility's policy regarding loss of the fire detection/spris system has been revised to include notifying the authority having jurisdiction (local fire department) and their teleph number.By revising the polic other residents who could be affected by this deficient prachave been corrected. Additionally, all staff will be inserviced on the policy revising garding notifying the author having jurisdiction (local fire department). This information be provided to all new hires annually to all other staff. The Quality Assurance Committee review each occurrence, as in happens, to assure the author having jurisdiction is notified the event of the loss of the fire	one y, all e ctice sion ority on will and e ee will it ority in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
		155738	A. BUI B. WIN	LDING IG		08/09/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹	•		ADDRESS, CITY, STATE, ZIP CODE	•	
MILTON HOME				1	//ARION ST I BEND, IN46601		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
	periodically b	periodically be instructed and kept			detection/sprinkler system.		
	informed with respect to their						
	duties under the plan. The						
	provisions of 19.7.1.2 through						
	19.7.2.3 shall apply. 19.7.2.2						
	requires all fire safety plans to						
	provide for the use of alarms, the						
	transmission of the alarm to the fire						
	department and response to alarms.						
	19.7.2.3 requires health care						
	personnel to be instructed in the use						
	of a code phrase to assure						
	transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents,						
	staff and visitors. Findings include: Based on review of the facility's policy and procedure book with the maintenance supervisor on						
	08/09/11 at 2:	35 p.m., the fire					
	watch procedu	are for an out of					
	service autom	atic alarm system was					
	not complete.	The procedure					
		uired telephone					
	number for the	e local fire					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155738 NAME OF PROVIDER OR SUPPLIER MILTON HOME				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN46601				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	supervisor sta record review	The maintenance ted at the time of , he had no other edure available to						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YMT921

Facility ID: 001141

If continuation sheet